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CLINICAL LECTURE.

INTERNAL AND EXTERNAL URETHROTOMIES.*

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INTERNAL URETHROTOMY.

IT is a good plan for patients about to undergo this operation or any other involving a possible wound of the urethra to have their urine sterilized or adulterated with some preparation of boric acid, as mentioned previously. The magnesian boracite (vide Martindale's extra Pharmacopeia) will be found preferable for this purpose to pure boric acid which often causes indigestion. The former may be given in teaspoonful doses in plenty of water three times a day, for three or four days preceding the operation.

In selecting this operation, the surgeon should satisfy himself beforehand as far as it is possible to do, by the examination of the stricture and the perineum, that the urethrotome may be made to cover the full extent, in depth and length, of the tissue forming the contraction, otherwise the operation will be of little permanent advantage.

Operation.—The urethrotome I have used for many years is that known as Maisonneuve's. Some improvements in the instrument have recently been made by Mr. Thompson Walker. It is adapted to the narrowest and most intricate forms of contraction, and as a rule requires no preliminary dilatation by other instruments.

Further, it can be made to complete its object by a single linear incision of sufficient depth to provide by careful after-treatment, as will be described, for the introduction of an ample splice of new tissue for the permanent enlargement of the contracted portion of the urethra. Multiple internal incisions are to be avoided as tending to increase the amount of cicatrix.

After many years' trial, I have not found Maisonneuve's operation open to objections that have been raised against it. These are that it may divide tissues unnecessarily or on the other hand, insufficiently. Though I have been in the habit of using the larger blade which cuts up to No. 23 Charriere (No. 14 English) I am not aware of there being any evidence of this having been excessive. On the other hand, when by the use of test bougies immediately after the section has been made, and before the patient leaves the room, there are indications that the stricture has not been sufficiently freed, a supplementary division of any remaining fibres or bands may be readily made by the use of Civiale's urethrotome, which will now enter easily.

If at the time of operation, the surgeon finds it impossible in one or both of these ways to quite free the stricture, he should not hesitate to perform in addition an external urethrotomy on the lines which will be described in cases where the combined operation is premeditated. This further proceeding in no way adds to the risk, whilst it greatly favors the prospect of success.

The technique of Maisonneuve's urethrotomy commences with the introduction of the fine filiform guide. To save time, this may previously be passed in the ward, but where there is difficulty or hitching this maneuvre be greatly facilitated by including it whilst the patient is under the anesthetic.

When the position of the guide is verified by the ease with which it moves it is secured on the metal director, and then the latter is made to follow its leader into the bladder;

*This is No. 2 of a series of lectures on this subject, delivered at the London Post-Graduate College. No. 1, on The Urethrotomies, appeared in the issue of September 10. To follow: (3) The Combination of External and Internal Urethrotomy.

this is usually indicated by the escape of a little urine along the groove.

If the stricture is extremely tight and there has been some hesitation in following up the guide to the bladder, the deposition of the director or metal portion should be tested by introducing the finger into the rectum. By this means the relationship of the instrument to the canal can be readily ascertained or adjusted.

If this prove correct, the urethotome blade should be placed in the groove of the director and gently and but firmly pushed along until the stricture is divided. Care should be taken to hold the director in correspondence with the median line of the body, as taken from the umbilicus downwards.

The operator should not do more than divide the stricture, avoiding touching the internal sphincter of the bladder, which though never strictured is usually temporarily contracted around the instrument. Therefore when the stricture is felt to be divided the surgeon should stop short of pushing the knife to other end of the groove or staff.

In Mr. Walker's modification of this urethrotome the groove stops at the curve in the director, so that any risk of wounding the neck of the bladder or prostate is avoided. I have rarely seen much hemorrhage when this precaution is taken. On the other hand, considerable bleeding may follow the unnecessary lesion of the prostatic ring.

The completeness of the operation should then be tested by the successive introduction of bougies. For this purpose Lister's metal bulbous instruments may be used, beginning for instance, with No. 12 (English) and gradually running up to No. 15. A catheter should then be passed—metal for preference —and the parts well sluiced with boric solution with which the bladder is finally filled.

And now commences that part of the treatment which is as important as the complete division of the stricture. As I can find little or no reference in text-books to the object now aimed at it will be necessary to describe it in detail. It relates to the permanent enlargement of the strictured portion or portions of the urethra.

By the incision which has been made the urethra is at once enlarged at its strictured portion, so as to permit a bougie not less than the normal size of the urethra being readily passed into the bladder. Otis demonstrated that the normal size of the urethra was considerable larger that that usually accepted. On this discovery modern lithotrity, as invented by Bigelow and universally practised, is used.

The after-treatment of an internal urethrotomy has for its object the conversion of the cleft made by the liner incision along the strictured roof of the urethra into an integral portion of the canal so as to add to its permanent dimensions. This is shown in these sections of the urethra, sketched at different periods.

1. 2. 3.

In this way it has been been demonstrated that endoscopically it is possible not merely to stretch a stricture, or to suddenly enlarge it by cutting it across, but to introduce a splice or interval of new tissue corresponding with the area of the cleft.

With this object in view and after the stricture has been divided in the manner described and the completeness of the division fully tested provision should be made for the retention of a catheter for some days. Unless this is done there is no guarantee that the incision may not close, either partially or in whole. The occasional introduction of a bougie as a substitute for the retained catheter is no safeguard against this liability, and the intermittent use of this instrument is in itself a cause of irritation, which a properly adjusted retained catheter should be free from.

Everything depends upon the manner in which a catheter is tied in. If it is done well it proves a comfort to the patient in voiding urine, if on the other hand, it is not artistically planned it is the reverse. A little trouble on the part of the surgeon makes all the difference.

The catheter should be made of the finest silk be coated with the best varnish suited for this purpose. After many trials I have found the French make of catheters for this purpose, as a rule, better than the English. I have frequently retained the former for ten days without removing them. Others in similar cases, I have had to withdraw in forty-eight hours, and found them corroded and commencing to be covered with phosphates. This should not happen with good tying-in catheters.

A retained catheter must be as correctly adjusted as a tracheotomy tube. Its length within the bladder should be carefully determined by means of a syringe before it is fixed. It should not project too much within the bladder, or it will excite irritation; on the other hand it should be sufficiently within the bladder so as not to occasion retention.

I seldom tie in a catheter larger than No. 9 or 10 English. These sizes are more comfortable to the patient than higher numbers. Their object is to keep apart the sides of the incision through the stricture until some degree of healing has been obtained. This usually occupies from three to ten days when the catheter may be dispensed with. The section of the stricture relative to the retained catheter is here shown. The catheter will be seen maintaining the cleavage.

The mode of fastening the catheter in when its length for drainage purposes has been accurately determined by trials with a syringe is by securing it with stout silk to the penis by one or two circles of rubber plaster.

The escape of urine should be controlled by a movable plug of ivory or hard wood removable when necessary by the patient or his attendant. It is of great importance in all these cases to obtain a nurse who has been well trained in surgery of this kind. These persons are by no means too abundant.

As long as the catheter is retained it should be washed out together with the bladder at least twice a day with warm boric solution, and care should be taken to have a suitable bed and mattress for bladder drainage purposes. A patient who lies in a hole will not drain well.

After the retained catheter is finally withdrawn, a point which is usually determined by the feeling of freedom with which the instrument may be moved relative to the urethra, the use of a bougie is not resorted to for some days, when a trial examination may be made with a soft instrument. In a considerable proportion of cases thus dealt with it will be found that no further instrumental treatment is necessary.

A precaution and until proof of the cure is well established, the occasional use of a bougie is recommended. All patients who have once had stricture should be instructed how to use a bougie. The failures to cure strictrue are for the most part traceable tc the want of such treatment as I have described after the division of the stricture has been made.

EXTERNAL URETHROTOMY.

This operation is applicable to exceptionally contractile strictures and to others where the urethra, perineum, and even the scrotum, may be included in a cicatricial mass which is undilatable and outside the reach of internal urethrotomy.

These cases may be subdivided into two: (1) When the patient is able to void urine with difficulty and pain and with a liability to attacks of sudden retention, and where the urethra is instrumentally impassable; and (2) when the conditions are similar, with this difference, that the strictured canal is open to some small instruments.

This two-class division is obviously an arbitrary one, dependent for the most part on varying degrees of contractility, spasm, the presence of false routes or passages, and also the individual skill of the operator.

Impassable strictures (not occasioned by prostatic hypertrophy) must be regarded from two points of view: First, in respect to temporary measures which may be necessary for relieving urgent retention of urine; and secondly, relative to the radical treatment of the stricture.

It must be remembered that no stricture can be strictly regarded as "impassable" which admits or has recently admitted prior to a complete retention of urine the passage of urine naturally, even in drops or in a fine stream.

This knowledge should serve as an incentive to endeavoring patiently and with gentleness to reach the bladder by the natural though contracted channel, and later on to attempt if necessary, the restoration of the latter by a more radical proceeding.

The great improvement that has taken place in the means for relieving retention of urine by catheterism during recent years has largely reduced the number of so-called impassable strictures. In fact it may be said that no stricture can be regarded as impermeable, unless the patient is or has been for some time provided with a urinary fistula. In practice, however, this refinement in reference to the term "impassable" cannot always be acted on. A sudden retention of urine occurs, the bladder becomes painfully distended, and by no ordinary methods can the practitioner give relief artificially in the direction of the natural passage.

Urgency of this kind is best temporarily relieved not by forcible catheterism, but by tapping the bladder with an aspirator or fine trocar, preferably in the form of pneumatic aspiration, immediately above the pubes where it is uncovered by peritoneum. This is a rapid and painless process, and may be repeated almost indefinitely—thus the patient is immediately relieved, time is provided for reflection as to what is best to be done of a more radical nature, and no further damage is inflicted on the already disordered urethra.

Instances are not infrequently met with where the removal of tension in this way enabled the bladder to regain its power over the stricture, and dilatation with some form of instrument was again resorted to with satisfactory results.

Should, however, this not prove so, and the urethra continues to be fitful, and at times impermeable both to urine and catheters or bougies, the operation known as "Wheelhouses" for impassable stricture may be advised. This proceeding is so well appreciated, and is to be found in all text-books that I need not refer to it at length.

I have not had much experience with it, as being brought up somewhat skeptical about impassable strictures, unassociated with one or more urinary fistula, I have generally succeeded in overcoming difficulties by patience, oil and filiform guides and so dealt with the stricture on the lines advocated in the previous article. Wheelhouse's operation, which is that of choice in impassable strictures, may be stated as consisting in opening the normal of the urethra on a special staff, half an inch in front of the stricture in searching by sight and probe-director for its contracted orifice, and having found it, dividing the stricture of the director thus used, and so restoring the canal to its normal dimensions.

The stricture having thus been divided a drainage tube is introduced and the case treated on the lines described in the previous article.

Wheelhouse's operation, having for its object the relief of retention where a stricture is impassable, may be made to answer the purposes of a perineal section, as described and applied in the next section to the combination of the two urethrotomies.

External urethrotomy, or perineal section without a guide in the form of a grooved metal staff passed fairly along the contracted urethra into the bladder upon which the division of the stricture can be safely accomplished, is an obsolete operation, which is not to be advised.

For instrumentality impassable strictures it has given place to Wheelhouse's method, whilst strictures which are passable, though for definite reasons requiring external section, are best treated by the combined operation which will next be described.

Dr. Albert H. Dollear, some time assistant to Dr. F. P. Norbury at Maplewood Sanatorium, Jacksonville, Ill., has been appointed assistant physician to the Western Illinois Hospital for the Insane at Watertown.

LEADING ARTICLES

OUR DUTY TO PROSPECTIVE MEDICAL STUDENTS.

A. L. BENEDICT, M. D.

BUFFALO.

The complaint is sometimes made that the medical profession is being crowded beyond the limit of tolerance, by recent graduates, sought by the colleges for mercenary reasons, and to the disadvantage of the existing medical body. Whatever truth there may have been in this complaint, in the past, the present is no time for recrimination. Never before has the medical profession been so well organized nor possessed of so great influence. For approximately fifteen years, it has been impossible for anyone, not reasonably well qualified according to both general educational and technical standards, to graduate in medicine, excepting by gross evasion of the law or by seeking states and colleges notoriously behind the times in their requirements. During these fifteen years, approximately a quarter of the medical profession, as it existed at the beginning of the period, have passed away and, without malice, it may be said that many of the funerals were urgently needed. In many ways conditions have been modified so as to tend to restore the influence of the practitioner of medicine, to restrict the teaching of medicine to a class of teachers, and to render this class independent of the fees of students, but, on the contrary, dependent for their tenure of prestige, if not actually of their positions, upon the quality of the students graduated. These tendencies have not reached the point of actual fulfilment of ideals and, still, they are genuine and they have already reached a point at which optimism is warranted.

Speaking approximately by statistics, the United States now has a few less than 180 medical schools, with an average attendance of 150 students. In the aggregate, these schools graduate about 5,000 annually, receiving, each year, about 7,000 new matriculants, of whom 2,000 are estimated to be weeded out by one process or another, before the completion of the course. Very few of the 7,000 fail to come under the influence, at one time or another, of some of the hundred thousand and more practitioners of medicine. Thus, the onus of the complaint can and should be referred back to its source.

First of all, each one of the army of more than a hundred thousand medical men, should realize his personal influence and responsibility in the matter. Not only in an aggregate, economic sense, but in an individ-

ual, professional sense, does the status of the profession depend upon the thoroughness with which each physician does his duty in controlling medical matriculations.

Secondly, while the economic problem of demand and supply ought to be considered by every trade and profession, this problem should not be studied in the narrow way of financial competition. There are undoubtedly too many physicians in the country—at least half of the existing body could be removed without overtaxing the strength of the other half to care for the health of the country. At least a thousand of the five thousand annually added to the profession, represent a surplus beyond the vacancies created by death in the profession and by additions to the population.

Still, conditions are by no means so acute as to justify or even to excuse the attempt, arbitrarily to exclude worthy aspirants from pursuing a medical course.

It is proper, however, to set before each prospective medical student, a candid presentation of the facts governing the financial and business status of the medical profession. A considerable proportion of the young men who contemplate medical practice have no special predilection for the work. They are seeking a dignified, not too laborious, and well paid occupation. Without being either lazy, actuated by false pride, or mercenary they select medicine as a life work, largely on business principles such as govern purchase and investment of any kind. If the real facts were presented to them, without prejudice, they would, in a large number of individual cases, choose some other profession or business, and in so doing, a substantial benefit would accrue both to themselves, to our own profession and to the community generally.

In other cases, special reasons render it advisable that a given youth should be directed into other channels of activity. It often happens that medicine is chosen because certain scientific studies, in which the high school or college student is especially interested, bear upon the practice of medicine. In many such cases, the abilities of the individual are of such a rank that he could do better work and attain a better standing by confining himself to the particular science in question.

In other cases, aside from a reasonable allowance for the carelessness of youth, the boy who would like to study medicine is so heedless and so utterly unable to do things in the right way that it is a mercy both to himself and to others, to direct him toward lines of activity in which mistakes may involve only slight commercial loss and not danger to human life.

Again, with due allowance for immaturity, some boys lack the moral nature which is demanded of the physician. Some one has well said that the physician must practice with his heart as well as his head, and many men, well enough adapted to a useful and honest business life, are not capable of the self-sacrifice, attention to details and disregard of personal convenience, which are part of the physician's duty.

Physical vigor is a desideratum for the physician, and yet, in this age of the world, many men of delicate health manage not only to do useful work in medicine, but to acquire a state of health not anticipated in their youth. More important is mental health and strength, for, incidental to the practice of medicine are many emergencies and experiences which call for ingenuity and clear-headedness and which work disastrously upon a neurotic taint. The time is past when the fool of the family should be selected to study medicine and the strain and actual exposure of medical studies demand at least a reasonable degree of physical and mental stamina, and the absence of positive disease and morbid tendencies.

It is, at once, the right and the duty of every physician to demand that the young man to whom he stands in the place of a preceptor—however much the old legal status of the preceptorship, has been modified—shall somewhat exceed the strict legal reqirements of the matriculant. The time is not ripe to require more than a high school education preliminary to admission to the medical school. Yet, the individual preceptor may and should insist that any student for whom he is morally responsible should give an overflowing measure. It may not be wise for any physician to say to every student, that he must take a full college course, but it is feasible to point out to him the broadening influence of at least a year of scientific and literary study in advance of the legal requirements. Too often, the preceptor assumes the narrow view that his student ought not to know more than he himself does. But advance is the spirit of the age and the wise father, preceptor or advisor, realizes that more is expected of the present than of past generations. Medicine, in particular, has developed in very recent years so largely along scientific lines, that further progress, or even the proper use of what we have already gained in principles, demands a broader and longer course of preliminary training than could have been considered necessary even ten years ago. Moreover, attainment is purely relative and the conditions at present are such that a college education demands no greater sacrifice and places a man in no higher grade than an academic education a generation ago.

The narrow utilitarian policy of urging a younger brother, nephew or son into a medical career, for the sake of subsequent assistance, or even because the senior may thus give greater assistance to the junior, for the latter's sake, is to be deprecated.

We wish to emphasize, particularly at this season, when medical colleges are about to open, that each one of the many thousands of physicians, should exert his influence in a broad and wise manner, so that the medical matriculants may be of higher quality than ever before. The fact that better quality implies a smaller quantity, and that this diminution in quantity is indicated by purely economic conditions, need not and should not influence the advice given in any particular case. Fortunately, the conditions are such that economic and humanitarian ends may be served by the same wise policy, and the consistent carrying out of this policy will gradually bring about, not a medical Utopia, but a condition in which an adequately paid and sufficiently busied profession shall enjoy the prestige which can only be attained by an even balancing of the general law of supply and demand.

THE annual crop of foot-ball accidents is about due. One accident has already been reported from the local field.

DR. HARRISON CONVICTED.— Dr. A. S. Harrison, of Kennett, Mo., one of the foremost physicians of that section of the state, was convicted in the Circuit Court of Stoddard County on the 13th inst. of mayhem, and sentenced to serve five years in the penitentiary. The victim of the brutal assault was a farmer, Daniel Crites, who, with Harrison and one John Sweeney, had spent an afternoon drinking and had gone to a vacant house together, where they were joined by a fourth man. Crites tried to leave and was struck on the head and lost consciousness. When he recovered he found himself on the railroad track and suffering great pain; he rolled off the track just before the train passed. With great difficulty he made his way to town, and there it was first discovered that he had been mutilated. Harrison and Sweeney were arrested for the crime. Harrison denied having entered the house with the others, and also denied all knowledge of the crime. The evidence is purely circumstantial, but seems to have satisfied a jury. It is believed that a new trial will be granted. If a member of our profession did commit such a crime, we can have no time for sympathy, five years is too little punishment; but if there is a chance that he is innocent every aid should be his to establish the fact. The crime, if committed by a physician, is more heinous for the fact.

TOBACCO SMOKING BY THE IMMATURE.— We hold no brief for the cigarette, nor do we fail to recognize the fact that smoking by juveniles is an evil, but the case for remedying the evil is not helped by doubtful statements. Everybody knows that tobacco is a poison and the suggestions, therefore, that tobacco is injurious because of its impurity or adulteration or because poisons are added to it are altogether beside the issue. If the tobacco smoked were the purest possible leaf the evil of smoking by juveniles, in our opinion, would be not a whit the less. If it were other wise there would be no necessity for suppressing such smoking so long as the youth was supplied with pure tobacco. Since tobacco is itself a poison we need no further argument against indulgence in it by the immature or its abuse by the grown-up person. We can well believe that certain tobaccos are more poisonous than others, but we very much doubt whether substances more injurious than tobacco itself are ever added to the manufactured leaf. Flavorings and sweetening substances, such as liquorice, glucose, and glycerine, are often added, but these are harmless compared with pure tobacco itself. Statements have been freely made that morphine or even cocaine is added to cheap cigarettes in order to give them immediate soothing qualities or "to soften" the flavor of an otherwise harsh-smoking tobacco. We cannot accept such statements applied, at all events, to cigarettes retailed at five or even six a penny. The tobacco in such cigarettes is of an inferior and inexpensive kind we admit, but we have not been able to find the smallest trace of foreign poisons in some very cheap cigarettes which we purchased only recently and submitted to careful analysis. We doubt whether it would pay to add such comparatively expensive poisons. Opium is not cheap nor is cocaine. Tobacco of common quality is at any rate infinitely cheaper. The danger of smoking arises from tobacco poisoning and it is the wholesale and unchecked poisoning of the child with tobacco, chiefly in the form of cigarette smoking, against which the nation is asked to find a remedy. On what lines such a remedy can be made effectual we are not sure. It is obvious that different persons exhibit a different susceptibility to the poisonous action of tobacco even in the same country. In Oriental countries, however, excessive smoking, which is intensified by inhaling the smoke, commences almost from the cradle and is continued right through life apparently without any ill-effects.—The Lancet.

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OFFICIAL TRANSACTIONS.

THE FEMALE PROSTATE.*

CHAS. E. BARNETT, M. D.

FT. WAYNE, IND.

DISCUSSION.

Dr. F. J. Taussig.—The subject is certainly one concerning which we have very much to learn and one in which I acknowledge to have had little experience. The question of gonorrheal infection of these glands is one not given due importance either in the text-books or in general practice. In the deep ducts the gonococcus may reside a long time when in other portions of the genital tract it has disappeared, and doubtless serves to renew the infection in many cases As regards the treatment in these cases, I don't know whether we ought to undertake very active treatment in any of these gonorrheal infections about the urethra. It will usually get well by itself, and if over-treated, the disease will spread to the neck of the bladder, or into these ducts. I am free to confess that in the sections I have seen they have always been in the form of ducts. They have a single canal that penetrates rather deeply. In the majority of instances these cases will get well without treatment. I recall one case of an abscess of these ducts, in which during labor the abscess was literally emptied by the passage of the head and the pressure of the labor pains, so that a stream of pus came out through the urethra. The pus can often be milked out through the urethra, and this is preferable to rupturing through the vagina. One of the cases I have seen needed surgical interference. In the Bartholinian gland we have a single racemose gland, and if the canal be closed the drainage is poor and there will be a tendency to abscess formation. In these cases mere incision is not enough. A complete extirpation of the gland is necessary. But in these para-urethral structures we have merely a duct, and from general reasoning I should imagine the indications for operative procedure would not be as frequent as stated by the essayist. I don't recall having read of or seen any case in which there was any great hypertrophy of the tissue around these ducts, such as is found in the male. Even in cases of pseudo-hermaphroditism I do not remember any case where there was the formation of a prostate in place of these ducts.

Dr. George M. Phillips.—The subject is an attractive and a new one. For the limited time I have been engaged in the practice of medicine I have treated the fewest possible number of women, and I have never had a woman remain obedient to treatment for more than the shortest while. We know today that there are new things so far as our information goes that should have been known to us a long time, and while these glands may be a counterpart of the prostate, yet it would require a great deal more to settle the question than what has been done. In the first place, there is a great deal about the prostate in the male that we don't understand. For instance, it was supposed when we commenced making prostatectomies that the ejaculatory power would be abolished, but I have made the operation in a number of cases where for several years the sexual power had been abolished, and following the operation the sexual and ejaculatory power had been restored, and in one case the man assures me that these powers are greater than ever before, and he is now 67 years old. Yet I was taught to believe that this was the principal function of the prostate. If that is true, a woman does not need such power. You believe, Dr. Barnett, that these enlargements were the result of an inflammatory process as far as you could determine?

Dr. Phillips.—Did this appear to be a fibrous process when examined microscopically?

Dr. Barnett.—I do not know.

Dr. Phillips.—We should feel deeply indebted to the essayist for bringing this matter to our attention. There may be a great deal more in it than we are at first inclined to think.

*Discussion of paper published August 25th, page 404.

Dr. Scharff.—This subject is a very interesting one. It has long been a question of the analogy of some gland or organ in the female with the prostate in the male. In the para-urethral glands referred to there is really not much real glandular tissue, while the prostate is to a great extent made up of glandular tissue. In gonorrheal affections of these para-urethral glands you find a small cell infiltration rather than a hypertrophy of the glands. In reference to the treatment of gonorrhea in the female I noticed that Finger establishes the location of his infection in one of four places, viz.: cervix uteri, urethra, Bartholin glands or para-urethral (Gänge) or canals, and applies his treatment to the affected part. It is also interesting to see how he draws the line of his responsibility from the gynecologist in these affections of the cervix, he treating them only as long as he thinks the disease is limited to the cervix, and has not gone over to the body of the uterus, tubes, etc., when he refers them to the gynecological department.

Dr. Bransford Lewis.—I had anticipated the pleasure of trying to tear his paper up the back. That is one of the pleasures in receiving guests from the outer world, but I think Dr. Barnett has taken advantage of us, preventing this by bringing in something that we don't know anything about. I cannot say anything against the contentions of the essayist. If he establishes his case it will make another focus of infection for us to look out for and disinfect. My experience with the gonococcus is limited almost exclusively to the male organism. In some cases we have found that active treatment was not well borne for certain length of time. They will then do better if let alone, so far as local treatment is concerned, for a certain length of time, yet I have no confidence in their getting well ultimately without treatment. I do not have confidence in the necessity of resorting to internal and general treatment until the acute processes are over. It is necessary to get rid of the gonococcus. I have no faith in the recovery of the individual otherwise. The gonococci must be eliminated by some direct and radical mode of treatment. In a number of cases in the course of our examination of male patients we have seen not a particle of discharge from the meatus, and after having the urine passed in two glasses both were found negative, and yet when we milked the prostate and vesicles down would come a number of drops of gonorrheal pus. This is an illustration of the absolute necessity of going after the nidus before that patient has a ghost of a show of getting well. We have had recently a case so remarkable that I have never heard of anything like it. This patient had three ureters, one on the right side and two on the left side. Of the two on the left, one was infected with gonorrhea and the other gave perfectly clear urine. That patient had been treated by a number of most capable men. He had for two or three years had persistent by recurring gonorrheal infection. He had received very thorough treatment, yet every once in a while up would come this gonorrheal activity. The reason for this was never learned until we saw the three ureters. Then by three irrigations of the kidney pelvis we cleared up the whole thing and he has had no recurrence of the infection in seven months. We tried to cure him and could not do it until we discovered this extraordinary source of infection. He might have gone on for twenty years just as well as for three years in this condition. It is not a matter of time; we must find these foci and Dr. Barnett has told us of a new one for the gonococcus. The more of these niduses that lie in the human organism the more difficult we find the work. I don't like to accept the burden Dr. Phillips has put on the prostate, that of accelerating the ejaculation of the semen I have looked upon it as an organism of glandular and muscular tissue with a fibrous tissue interlacing these two. The muscle at the base is a sphincter muscle for the bladder, and I would not expect the prostate to have the office of expediting the ejaculation of semen.

Dr. Jacobson.—I do not agree with Dr. Taussig that we should not attack these foci. Especially in the chronic stage we ought to find them and with the new aids we have for the treatment of gonorrhea we ought to cure them, or I should say, assist the antibacterial forces of nature to bring about a cure. The different portions of the urethra can be exposed and the retention cysts can be slit up. Then apply strong nitate of silver on applicators under the direct light of the electric endoscope. This treatment repeated frequently with assistance of antitoxins or antibodies found in the blood of the patient to bring about a cure. I believe in the greater majority of patients that have an attack of gonorrhea, the gonococci entirely disapears in from three to ten years, and greater number of males that have had said infection are able to discharge lively, healthy spermatozoa.

Dr. Jacobson.—Certainly I have failed. It is much easier to locate these glands in the female than in the male. Sometimes they do not form retention cysts. You may press through the vagina and the pus will come right out. Ashton uses a strong ichthyol solution

on applicator wrapped with cotton. If you let them alone, as advised by one of the preceding speakers, reinfection will often take place and the tubes may become involved, then you will have a salpingitis and a dangerous operation confronting you. And always bear in mind when you find it necessary to remove the tubes, there may be such strong adhesions that you have to exercise great care and patience in their removal to prevent rupture of the tube or tearing a hole in the adherent bowel or bladder. Calculi have been found in these little pockets or cysts; there may be tuberculosis present, then excision with general antitubercular treatment is indicated.

Dr. Norvelle Wallace Sharpe.—The ordinary infection is not very troublesome to the patient or to the physician in charge. Any infection which may be cured by the instillation of fluids is not troublesome, nor is it serious even when encountered in glands that may be removed. The real difficulty arises when the infection occurs in glandular structures where the focus is not easily reached. If it can be cured by a simple milking process, well and good. Fortunately the female urethra is short and we may readily expose the orifices of the ducts, or we have the further opportunity of splitting up the duct so as to reach the infected gland. The entire interest in this matter rests in the fact that we have a focus from which a re-infection may be started up at any time upon provocation. As to the surgical procedure, the following will prove a satisfactory routine: cleanse the urethra, examine the urethra, ascertain ducts from which pus or infected material escapes; cleanse same and instill what medicament seems indicated. If this prove insufficient, split ducts and make thorough local applications; if this too proves inadequate, extirpate the infected masses from the vaginal side. Suturing if the operation has been in normal tissue, packing if it has not.

Dr. Wolf.—I have had much experience in this matter because I was chief of Professor Lange's clinic in Vienna. The discussion has drifted a little from the subject presented. Dr. Barnett has presented something with which I have never met. These are not at all glands, they are only ducts. In the normal cases, they have not a trace of glandular tissue. I have never met a case where these ducts communicated with these glands. Dr. Barnett tried to make an analogy between these and the prostate. Possibly if he gave us a histological demonstration we would be readier to see the resemblance. I have seen these ducts involved, and at Professor Lange's clinic we had the surgical method of splitting. We entered with a probe and then introduced a very fine scalpel and opened them. You cannot do the work by injections. The female urethra is very hard to treat, unless you have had large experience. We never forced the injections, always gently pressing in only so far as was easy, and I never got any infection by this means. It is very important to give attention to these para-urethral ducts. This is the first time I have ever seen any communication between the para-urethral ducts and the glands. It is, therefore, surprising to me to hear of these cases. The analogy is something really striking. Dr. Barnett has presented something new, and if he only would have taken the time and care to show us histological proof, I would be glad to say that we have had the demonstration of a discovery.

Dr. Barnett, in closing.—In naming this paper "The Female Prostate," the question came to me whether medical men would not look upon that as belittling the subject, or putting out a red flag to attract attention. In my opinion, and I have been investigating this subject for four or five years, we have the histological proof. If I had named my paper the "Deep Urethral Glands," the man practicing medicine would have thrown it aside, and said it was nothing to him. Some of the older men will tell you of the formation of an abscess and the reformation, etc. I just wanted to bring the subject to the attention of the profession. If I am wrong I want to be set right, and if some one will prove that we have abscess formation without glandular tissue, which to my mind is practically impossible. And, according to the size of the abscess, there is enough to call attention to it, even if there is no glandular tissue. Dr. Phillips is a doubting Thomas. I have found hypertrophic glands in a number of dissections. I had a section for Dr. Sharpe to examine, but somehow the section never got there, but I believe the tissue was both glandular and muscular. As to the analogy, we have the prostate in the male and the deep urethral glands in the female, we have Bartholin's glands and the vesiculae seminales. As to constitutional trouble from the Neisserian infection, I think we have more constitutional trouble than from any other infection with the exception of tuberculosis. In the bladder work I think Dr. Lewis is at the very top of the heap. Understand me, I don't believe this is a big subject, but I do believe it is a little subject that needs attention. I believe there is communication between the duct and the gland, and that it will be proven histologically.

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EDITORIAL

Specialism as it Sometimes is.

WE often hear it said that we live in a day of specialism in all lines of commercial and scientific activity, and in the abstract this appears to be an ideal state, but it is an unfortunate fact that the term "specialist" has, in medicine, no necessarily limiting or warranting signification. The problem of specialism would be simple indeed were specialists always men of special attainment in their special line, and did they confine their attention to the work to which they profess to limit themselves. We have in mind a man recently arrived from the University of Vienna, but shortly graduated, who posed as a specialist, telling of special training to bear out his claim in gynecology, pathology and bacteriology, surgery, urology, dermatology and internal medicine, all within a few weeks, his line depending on his audience. He was getting his bearings when he found the line he thought the most promising in this community, he announced himself a specialist therein, but there is no indication that he confines himself to it. Graduates of American schools are less rash, for they know local conditions and appreciate that they cannot command so credulous an audience, but their real unpreparedness when they announce themselves as specialists is frequently quite as apparent. A four years spent in medical study does not prepare a man to launch himself as a specialist, such an one must spend years rounding himself out in general work and special post-graduate study before he is fit to be regarded as specially an authority in any brach. Speaking to this point the editor of the Post-Graduate says:

"We have always considered it an axiom that a man may be an excellent physician without knowing anything at all about surgery, but we believe just as firmly that no man can be a first class surgeon who is not a good physician. The reasons will easily appeal to any thinking man, but when we state the fact that there are a number of surgeons in our experience who are extremely skillful in surgery itself, and yet cannot grapple with the simplest medical complication in a case, we are not putting too high an estimate upon the necessity of the surgical practitioner keeping up his reading and observation, and, if he can do so, his experience in general medicine. When it comes to the narrow specialties of the eye, ear, throat, and so on, the same dictum holds, and the failure to attain the best results is often due, not to the lack of skill in the specialty, but to the lack of knowledge in general medicine."

A knowledge of general medicine and the maintenance of a well-rounded medical character is essential to success in a specialist's work. We all know specialists who can see only their own little group of organs, and who view every obscure trouble as originating from some disorder within their province. Acute diagnostic acumen would frequently send cases to the internist or back to the general practitioner which are treated by the urologist. We too infrequently hear of a specialist returning a patient to the general practitioner, because he fails to find anything within his province; he doesn't fail, because to him every symptom points to his field, and he can see no other.

The real day of specialism will be the time when only those will aspire to this dignity who have drunk deep of learning and who have a breadth of scientific horizon which brings within their vision the whole realm of medicine, even though they may not choose to tread all its devious and varied paths.

Such there are now, and it is to them that we look with gratitude for they keep the good word specialist from utter disrepute.

The Missouri Tuberculosis Sanitarium.

THE laying of the corner-stone of Missouri's State Sanitarium for the Treatment of Incipient Tuberculosis occurred at Mt. Vernon on August 15. The ceremony was conducted under Masonic auspices and were all in impressiveness that the Masonic rites assure. Addresses were delivered by Mr. W. B. Skinner, of Mt. Vernon, Governor Folk, Dr. Wm. Porter and others, each picturing the responsibilities and possibilities of the institution.

In his address Gov. Folk said: "The establishment of this sanitarium marks an important epoch in the history of Missouri and is a milestone in the progress of intelligent warfare against disease. It is now a demonstrated fact that consumption can be cured by the methods to be used here. It is a duty the State owes people, to save, if possible, the multitude of victims who are sacrificed each year to this malady."

The Governor failed to turn a graceful compliment to the professiyn of the State. The institution is a direct result of the initiative of the profession and its concerted action, and it is a little surprising that he failed to mention this fact.

It is gratifying to the profession that our State has inaugurated in this enterprise a campaign against tuberculosis; hitherto private ventures alone have offered to the victims of this dread disease a retreat where they may have the open air treatment under scientific supervision. The work of the institution will necessarily be confined to incipient cases, but with the growth of appreciation of its work on the part of the public there will doubtless be other like hospitals provided for more advanced cases.

The St. Louis Medical Society of Missouri.

THE long desired and much needed domicile of the St. Louis Medical Society was dedicated at the meeting of that body on September 15th, and the fact marks the beginning of a new era for the society. A report of the dedication will be found in another column. The building adjoins that of the Medical Library, on the East; it is at present a one-story structure; it is constructed with walls of a strength to allow for a second story should there later be need. The auditorium is nearly square with a rostrum for officers and speakers on the middle north side, the seating begins with a first row about ten feet from the rostrum, and each row some six inches higher than the one in front. Two hundred and forty-five opera chairs are in place for regular use, and there is a wealth of vacant space, wide aisles and open floor at the back of the room and on the right and left of the rostrum, making an emergency capacity of double the normal. The decoration is handsome, though simple, the walls are finished in pressed and enameled brick, and the ceiling is paneled in dark oak. The lighting is incandescent electric and the chandeliers are very great additions to the attractiveness of the room. From the lobby to the secretary's desk telephone communication has been installed, which will lessen confusion during meetings. The acoustics of the room are admirable. The lobby, the committee room and the coat room leave nothing to be desired.

The St. Louis Medical Society began its legal existence in 1837; during all the years since until now it has always depended upon some other organization for a meeting-place, and has been for considerable periods, at different times, in quarters where, but for the character of the body, its tenancy would not have been allowed by those in control. The scientific achievement of the society has been such from its beginning as to command the pride of its present membership, but its business management has never before been aggressive. Some four years ago the first steps were taken which have resulted in the present happy condition; reorganization, an interest in increased membership and consequent growth, the development of an esprit de corps which is both scientific and social, and has the business interest of the body for its foundation, have all been fruits of this season. The society has nearly doubled its membership within this period, and this will continue until eligible material is exhausted. With an attractive home, with a growing spirit of friendliness, and with such interesting programs as we have had for months past the society must grow. We owe much to those who have had their shoulders at the wheel for years past, and who have constantly had the welfare of the society at heart, we also owe much to the new blood which has lately come to us and has infused new life into our scientific programs and into the councils of the body.

The future of our society is in safe and conservative hands, and the outlook is happy indeed.

CARDIAC DISEASES IN DOCTORS.—Official statistics show (Amer. Med.) that 44 per cent of Austrian physicians die of heart disease.

THE NEW WOMAN IN SWEDEN.—The girls of Sweden within the past generation have entered fully into the movement for opening new careers to women, and if one of them decides to prepare for a profession, to take up literature or art, or to devote herself to some form of study or research, no one is surprised. Last year there were in Sweden three women doctors of philosophy and nine doctors of medicine engaged in the practice of their professions. There was also a lady doctor of laws, who has been appointed to a lectureship at the University of Upsala. Madame Sonia Kovalesky, the famous woman mathematician, was the first woman appointed in Sweden to a university professorship.

THE REVIEWER'S TABLE

Books, Reprints, and Instruments for this department, should be sent to the Managing Editor, Century Building, St. Louis.

PROGRESSIVE MEDICINE. Edited by Drs. Hobart A Hare and H. M. R. Landis. Volume II, June, 1906. Issued quarterly. Octavo, 368 pages. Philadelphia and New York: Lea Brothers & Co. (Price, paper, $6.00 per year; cloth, $9.00)

The contributors to the present volume of Progressive Medicine are Dr. Wm. B. Coley, who gives a very satisfactory resume of recent literature on hernia, together with much that is original, including splendid descriptions of operative technique for femoral hernia, undescended testes and for the radical treatment of hernia in children; Dr. Edward M. Foote considers Surgery of the Abdomen, exclusive of Hernia. The peritoneum and its drainage, tuberculosis of the mesenteric glands, gastric hemorrhage and ulcer, various injuries and disorders of the intestinal tract, the appendix and the liver and biliary passages are considered in the light of the latest researches and make the section one of the most valuable. Gynecology is presented by Dr. Jno. G. Clark, who considers in an exhaustive way: Carcinoma of the uterus, the myometrium, the uterine muscle during curettage, retrodisplacement, pelvic varicosities in women, gonorrhea, etc.

Dr. Alfred Stengel considers the blood in the various anemias and in other pathologic conditions, diabetes, gout, hemophilia, Hodgkin's disease, exophthalmic goitre, etc. Under the heading "Ophthalmology," Dr. Edward Jackson considers a considerable range of the subject, his contributions being briefer but not less important and instructive than those earlier in the volume.

The contributors to the volume other than the above are: Dr. Wm. T. Belfield, Jos. C. Bloodgood, J. R. Bradford, Floyd M. Crandall, Wm. Ewart (London), Edward M. Foote, Chas. H. Frazier, Wm. S. Gottheil, D. B. Kyle, H. R. M. Landis, Richard C. Norris, Robt. B. Preble, B. A. Randall, W. G. Spiller and J. D. Steele.

THE PRACTITIONERS' LIBRARY—CARR'S PEDIATRICS. The Practice of Pediatrics by Eminent Authorities. Edited by Walter Lester Carr, M.D., Consulting Physician to the French Hospital; Visiting Physician to the Infants' and Children's Hospital, New York. In one very handsome octavo volume of 1,014 pages, with 199 engravings and 32 full-page plates in colors and monochrome. Philadelphia and New York: Lea Brothers & Co., 1906. (Cloth, $6.00 net; leather, $7.00 net; half morocco, $8.00 net.)

This volume is unqestionably one of the most important additions to medical literature which has appeared this year. Considering the importance of the branch, pediatrics has been relatively neglected by writers; many divisions of our art which are of infinitely less importance are far richer in their literature. Nevertheless we have excellent works on the subject, and we are glad to have in this another which will rank with the most up-to-date and authoritative.

Pediatrics is a recent science. We can all remember when it was the common opinion that anyone could treat the baby, the new graduate felt that for this at least he was perfectly competent; but recent years have brought about changes and we now recognize the fact that the most profound learning, maturity of experience, keenest diagnostic acumen and well developed therapeutic wisdom are the right of those who are infants.

This volume deals in a masterly manner with the various ills to which infants are subject, dealing at length with each subject, and very completely covering the most recent advances of knowledge in each section. The contributors to the volume are the foremost of America pediatrists, and it is a satisfaction to us in St. Louis to see among these one of our own number, Dr. Geo. M. Tuttle, who considers the Diseases of Nutrition, rachitis, scorbutus and marasmus. The chapter is a strong one.

Throughout the work there is a very proper accentuation of hygiene and preventive measures, the feeding question occupies 86 pages, and as presented by Dr. Thos. S. Southworth is a classic. Equally important and equally excellent is the division of the work devoted to diseases of the alimentary tract, by Dr. David Bovaird, Jr.

This volume is one of the series announced by Lea Brothers, which purposes a comprehensive view of the major divisions of medicine outside of General Medicine, to wit, Gynecology, Obstetrics and Pediatrics. The series should be in every medical library.

NEW BOOKS.— Messrs. W. B. Saunders Company announce for publication in the early fall the following works: Keen's Surgery, Its Principles and Practice (Volume I); Sobotta and McMurrich's Human Anatomy (Volume III); Webster's Textbook of Gynecology; Hill's Histology and Organography; McConnell's Pathology; Morrow's Immediate Care of the Injured; Stevenson's Photoscopy (Retinoscopy and Skiascopy); Preiswerk and Warren's Atlas of Dentistry; Goepp's State Board Questions and Answers; Lusk's Elements of Nutrition. The most important announcement is the new work on surgery, edited by Dr. W. W. Keen, complete in five octavo volumes, and containing over 1500 original illustrations. The entire work is written by the leaders of modern surgery —men whose names are inseparably associated with the subjects upon which they have written. Keen's Surgery is intended to represent the best surgical practice of today.

DEDICATION OF THE ST. LOUIS MEDICAL SOCIETY'S AUDITORIUM.*

On Saturday, September 15, 1906, at 8:30 p. m., the new Medical Auditorium of the St. Louis Medical Society was opened with appropriate ceremonies. The Auditorium is located on a piece of ground adjoining the St. Louis Medical Library building, 35th and Pine streets. It is built in amphitheater form, with about 400 opera chairs and room for many more seats for special occasions. It has a handsome beamed ceiling and dependent chain chandeliers. The walls are polished brick.

The hall was well filled when the meeting was called to order by the President of the society, Dr. George Homan. The President made an introductory speech.

REMARKS BY GEO. HOMAN, M. D.

The St. Louis Medical Society; Our Distinguished Guests, Friends and Members:

Three score and ten years ago, lacking a few months, this society was ordained, constituted and declared a body corporate and politic by an act of the General Assembly of Missouri, the expressed purpose of such legislation being the improvement of medical literature and science, and to give dignity, permanency and usefulness to this body.

Measured by the Scriptural standard this society has survived the full span allotted to individual human life, has reached patrichal years, but until the present hour, so far as the record shows, this corporate body has never had a roof above it that could be called its own; it has possessed no domicile, no fixed abiding place—and the exercises arranged for this evening are in celebration of the fact that finally this reproach has been put away; we meet to exchange felicitations that at last a modest foothold on the earth has been secured, a point of vantage attained from which we can with confidence press forward to better things.

For it can hardly be doubted with the wondrous outreachings of science and the zeal of workers in its many lines that this spirit will be reflected here, and our membership will be so multiplied and attendance so increased that these walls, welcome and sufficient as they now are, will soon be found too narrow and a more spacious temple will have to be provided to meet the growing pressure of scientific and professional demands.

That the present happy achievement was made possible may it is believed, without invidious reflection, be traced to the wisdom of the society in 1895 in the selection of its treasurer who upon his induction into office found claims amounting to several hundred dollars, and almost nothing in the treasury with which to meet this indebtedness.

But gradually by prudence, thrift and good management better business methods were introduced; and, after eight years of such faithful service, when he was called to the presidency a very comfortable bank account had been accumulated to the credit of the society, and from this nest-egg has sprung the edifice in which we are now assembled.

The funds thus made available for investment in this property have been supplemented by contributions secured chiefly from the membership, and while the individual response to this appeal has been liberal as a rule, all things considered, still the names of very many of our members have not as yet appeared in the list of givers to this cause, but the hope is confidently indulged that such oversights and omissions will promptly be repaired when the situation is better understood. The particulars with respect to the maturing of this project, the preparation of plans, and the prosecution of the work of construction; the canvas made for funds to carry it to completion; the furnishing and equipment and the future cost of operating the building for our uses, will all be duly presented to you by the chairmen of the several committees concerned.

There are present here tonight some who have come down from a former professional generation, and who have personal knowledge of the vicissitudes and embarrassments that beset and confronted the organized profession here in earlier years, progress being hindered perhaps by bickerings or felligerency often due to mere misunderstanding or imperfect acquaintance, and leading to occurrences that were regrettable and sometimes even injurious to the advancement of scientific work and the promotion of lasting harmony among brethren.

Happily for us of today a more pacific spirit seems now to be in the air, a disposition to cultivate peace that extends even to nations which are rivals and competitors in many fields, and if this spirit can be brought sensibly to bear in the sharp contentions of races and governments, there is small excuse for a different manifestation among those so advanced in humane civilization as the medical profession is universally conceded to be.

In illustration of feelings that are sometimes permitted to influence the actions of men it may be permissible here to repeat the oft-told story of one of the earlier English wits, for the reason that its moral has an every-day and never-failing fitness of application. Briefly, then, this noted man of letters and

*Reported by Dr. Gradwohl, St. Louis.

wit was walking with a friend in London when he paused and pointing to a person across the street, said, with emphasis, "I hate that man!" In some surprise the friend asked who the person was, and why he was hated. The answer was, "I don't know him, and that is why I hate him!"

As the climate of feeling and opinion generally appears to have become more moderate, this occasion presents a most fitting opportunity to express the sincere hope that no wrongful or unkind contention between members may ever be brought across the threshold of this building; that the supreme, the controlling obligation of thorough, honest, unflagging scientific work shall never be lost sight of within these walls; that the doors shall never be closed to the truth, howsoever unwelcome it may appear at the time or by whom presented; that this rooftree shall be broad enough to afford hospitality and welcome to every honest thinker who believes that he has a new message to deliver for the betterment of his fellowmen—in short, that here is a temple dedicated to truth, science, progress; consecrated to peace, concord, unity, good will, so that the generations yet to come may be the better for our lives and labors, and gratefully say, They are justified in their works, they builded even better than they knew!

The program included the report of the chairman of the Committee on Arrangements, Dr. John C. Morfit. Dr. A. R. Kieffer, chairman of the Building Committee, reported upon the cost of the building, stating that there was a debt of about $2,000 to be cleared. He said that the building of the Auditorium would stimulate interest in the society work.

Dr. LeGrand Atwood, one of the oldest living members of the society, made an address upon "The St. Louis Medical Society in Its Earlier Years." He said among other things that his acqaintance with this society dates back to 1846, when he first attended its meetings. The first discussion he had heard upon the floor of the society was one between Drs. Wm. Johnston, Hammond and McPheeters. Notwithstanding the great changes that have taken place in the science of medicine since that, it remains to be said that the early members of this society were not fools by any means. They were as faithful to the requirements of the profession as we have been. He said that he wished the duty of speaking upon this subject had fallen to abler shoulders. He said that he presumed the honor had fallen to him because of his extreme age. (Laughter.)

He said that the first attempt at organization of this society occurred on December 25, 1835, when a meeting was held in the old Masonic Hall in this city. Dr. Wm. Carr Lane was once president of the society. Dr. Lane was elected eight times mayor of the city of St. Louis, only refusing the office again because of stress of professional labor. The speaker called attention to the greatness of Dr. Lane from a medical as well as from a civic standpoint, and said that he hoped that at some future time the physicians would succeed in having a monument erected to him in City Hall Square. At the meeting above alluded to, the society was formed and organized. At a meeting on January 2, 1836, the constitution was adopted. The officers for 1836 were: Dr. J. C. Farrar, president; Dr. Lane, vice-president; Dr. B. B. Brown, recording secretary, and Dr. Y. B. Bouting, treasurer. On January 15, 1836, the by-laws were drafted and adopted. The first paper read before the society in regular session assembled was, "Does Epidemic Contagious Puerperal Fever Exist in St. Louis?"

Dr. Farrar was the first American physician in St. Louis. The other physicians were French. On September 24, 1836, the St. Louis Medical Society appointed a committee to confer with the faculty of the St. Louis University, relative to the establishment of a medical school in this city.

Later in the same year, the society took up the matter of disciplining some members who were advertising in the daily papers.

The society also took up the matter of keeping a record of births and deaths which forms the basis of the present-day mortality records of the Health Department.

Dr. Barnett at this time offered a resolution governing the sale of milk, which is the first attempt at pure food legislation here.

A committee took up the matter of preventing the spread of contagious diseases.

In 1850 the society adopted the code of ethics of the American Medical Association. In 1877 the society adopted a resolution that only medical men could be appointed health commissioners of the city. In 1887, Dr. McPheeters introduced a resolution calling for the creation of a real estate and building committee, for the purpose of securing a permanent home for the society. The project was dropped on account of inability to secure money enough to buy the property. Had the society bought the property on 16th and Locust streets, which was at that time very cheap, and held it, the gain would have been several hundred thousand dollars, as this piece of property sold for that sum a short time ago.

Dr. R. M. Funkhouser, chairman of the Finance Committee, reported briefly that

there was a small balance of the money subscribed by the members remaining unpaid, but that several thousand dollars had been borrowed from the bank to complete the building of the Auditorium. He stated that he was ready to receive new subscriptions to cover this loan. He was followed on the floor by Dr. Pinckney French, chairman of the Committee on Business Affairs, who received the key of the building from the president, and then forthwith addressed the members on the need of paying off the loan spoken of by Dr. Funkhouser. Dr. French proved that his reputation as a financier was well grounded by addressing the members present, and in a short time succeeding in obtaining practically all the needed money, he leading off with a generous subscription, followed by Drs. Outten, Homan and others.

Dr. W. B. Outten gave an address on the "Medical Profession of St. Louis of Today." He ascribed the difficulties in the past in the way of unification of the city's profession to the Civil War and its political effect thereafter. He said that up to 1864, the profession was powerful, influential and united in its work in St. Louis, that St. Louis was a great medical center, but that from 1864 to 1895, elements adverse to the St. Louis medical profession took deep root and hampered the work. He said that in spite of the great adversity and strife in the ranks of the profession, the St. Louis Medical College lived on. He rendered a tribute to this college for its unflinching spirit in times of adversity. For the future he predicted great things of the St. Louis Medical Society and the profession of this city. He opined that the city would rise to great heights commercially in view of its central situation in the United States, and he predicted in a brilliant flight of oratory the commensurate professional progress.

Dr. W. G. Moore finished the program with an address upon the "Future of the Medical Profession of St. Louis." He said that he found his text for his address in the brilliant illumination proceeding from this building as he entered it this evening: Let your light so shine that others seeing your good work will follow after you.

He called attention to the discord and lack of harmony in the profession in the past, and made a strong plea for peace and good will for the future. He called attention to the altruistic work of the men who have attended regularly the meetings of the city and state societies; men who have gone by circuitous roads of travel to state meetings, neglecting their business, purely for the purpose of maintaining an organization. He spoke of the great work of organization of local and county society, work which has been so well stimulated by the American Medical Association. He said that this society will become the society of the young men before him. The young men must perpetuate it. Unless the young men prove faithful and true, the structure will be like a house of cards. The finest road to success is the road of peace.

Rapid School Inspection.—In accordance with a law passed by the Masachusetts Legislature, all the school children in the State will be regularly examined by physicians appointed by the local health board. In Fall River, with a school population of 21,000, twelve inspectors have been appointed, and they will be required, it is stated, to complete the preliminary inspection of the public and parochial schools during the three school days of the first week of the fall term.

Diagnosis of Gallstones.— Gallstone cases almost give a precedent history of rebellious dyspepsia. In a patient presenting dyspeptic symptoms, not clearly due to some other condition, the suspicion of the presence of gallstones should, therefore, be early entertained. The presence of a tumor in the region of the gall bladder is by no means necessary to the diagnosis of cholelithiasis. The bladder may be filled with stones, and yet shrunken instead of distended. In the presence of an obstructive jaundice, at any rate, Courvoisier has pointed out that distention of the gall bladder is far more often due to malignant growth or to pressure upon the common duct than to gallstones.—Internat. Jour. Surg.

Canada Association Meeting.—The thirty-ninth annual meeting of the Canadian Medical Association, held in Toronto August 20, was only an executive session, owing to the meeting of the British Medical Association. The attendance was about 75, and the chief item of business was the reception of the report of the committee on reorganization, which was presented by the chairman, Mr. I. H. Cameron. The report took the form of a proposed new constitution and by-laws patterned somewhat after the constitutions of the American Medical Association and the British Medical Association. After some discussion it was decided that the subject should be thoroughly dealt with next year. Montreal was selected as the place of meeting in 1907. Dr. A. McPhedran, Toronto, was re-elected president; Dr. H. B. Small, Ottawa, was re-elected treasurer, and Dr. George Elliott, Toronto, was re-elected general secretary.

SOCIETY NOTES

TRI-STATE (ALABAMA, GEORGIA, TENNESSEE) MEDICAL SOCIETY.—The eighteenth annual meeting of the Tri-State Medical Society of Alabama, Georgia and Tennessee, will be held at Chattanooga, October 2-4, 1906. Reduced rates have been obtained from all points in Alabama, Georgia, Tennessee, Mississippi, Louisiana and Florida, and an unusually large attendance is assured. The preliminary program includes an excellent list of papers from leading medical men of the South. Strong pressure will be brought to bear to ultimately convert this organization into a branch of the Americal Medical Association—The Association of the Southeastern States, and recommendations will be made at this meeting. Physicians desiring to read papers should send their titles at once to the secretary, Dr. Raymond Wallace, Chattanooga, Tennessee.

MISSISSIPPI VALLEY MEDICAL ASSOCIATION.—The next event of National interest will be the annual meeting of this association, which will occur on November 6, 7 and 8, at Hot Springs, Ark., under the presidency of Dr. J. H. Carstens, of Detroit. A program of more than usual merit has been prepared by the efficient secretary, Dr. Tuley, including three orations, by President Carstens, and Drs. Frank P. Norbury and Florus F. Lawrence. Extensive preparations have been made by the profession of Hot Springs for the entertainment of members, their wives and daughters, and a cordial welcome awaits them. Reduced rates will be in effect on all lines of railway, the Missouri Pacific and Iron Mountain System offering special service and through trains for the occasion. For full particulars regarding rates, call at city ticket office, or write the editor of the FORTNIGHTLY.

MEDICAL SOCIETY OF THE MISSOURI VALLEY.—The nineteenth annual meeting of this society was held at Council Bluffs, September 6 and 7, with an attendance of 125, Dr. Jno. E. Summers presiding. The program included twenty-five papers, and the discussions were most interesting and instructive. Among the guests at this meeting, who read papers, were Dr. Emil Reis, of Chicago; Dr. L. L. Uhls, superintendent of the State Hospital for Insane, Osawatomie, Kas.; Dr. Leo M. Crafts, Minneapolis; Dr. Alfred Schalek, Omaha; Dr. E. W. Clark, president of the Iowa State Medical Society, who responded to the address of welcome given by Congressman Smith of Council Bluffs. The society was royally entertained by the local members at the street carnival, and given a reception at the Elks Club. Dr. O. Beverly Campbell, of St. Joseph, was unanimously chosen as president of the society for the ensuing year and other officers were elected as follows: Dr. W. F. Milroy, Omaha, first vice-president; Dr. C. O. Thienhaus, Milwaukee, second vice-president; Dr. Donald Macrae, Council

O. B. CAMPBELL, M. D., St. Joseph, Mo.
President-elect Medical Society of the Missouri Valley.

Bluffs, treasurer (re-elected); Dr. Chas. Wood Fassett, St. Joseph, secretary (re-elected). The secretary's report showed the prosperous condition in which the society finds itself at the close of the year, having gained forty-four new members and losing but one. The annual Missouri Valley excursion to the A. M. A. was made a subject of special comment, and the secretary expressed the opinion that the next trip to Atlantic City would be even more enjoyable, if possible, than the last. Following is a list of members admitted at this meeting: Robert R. Hollister, F. W. Lake, L. B. Bushman, Alfred Schalek, S. Cole Little, and C. W. Pollard, of Omaha; J. H. Gassan, Albert V. Hennessy, T. B. Lacy, Jr., John F. Sprink, of Council Bluffs; Halsey M. Lyle, Kansas City; William H. Chapman, Ingleside, Neb.; William H. Anderson, Dunlap, Ia.; J. N. Medill, Persia, Ia.; J. R. Hollowbush, Rock Island, Ill.; James W. Lehan, Dunlap, Ia.; C. V. Artz, Hastings, Neb.; H. P. Duffield, Marshalltown, Ia.; Charles L. Mullins, Broken Bow, Neb.; W. R. Young, Ausley, Neb.; H. D. Spencer, Oakland, Ia.; W. F. Pierce, Carson, Ia.; L. L. Uhls, Osawatomie, Kas. The papers and discussions will appear in the Medical Herald, the society's official journal.

REPORTS ON PROGRESS

Comprising the Regular Contributions of the Fortnightly Department Staff.

INTERNAL MEDICINE.

O. E. LADEMANN, M. D.

Blood Pressure and Pigmentation in Addison's Disease.—Short (The Lancet, Aug. 4, 1906) publishes a case of Addision's disease, on which many observations were made on the bood pressure. He summarizes his paper as follows: The symptoms of Addison's disease are due to vasomotor paralysis. This is due to absence of adrenalin, the normal excitant of the sympathetic nerve endings, from the blood. The pigmentation is due to vascular relaxation of the skin causing exaggerated functional activity of the pigment cells. The most promising line of treatment, on theoretic grounds, is the administration of vasoconstrictors of prolonged action; digitalin has given good results in one case.

A Case of Acute Rheumatism, Hypyrexia; Recovery.—Smith (The Lancet, Aug. 4, 1906) records a unique case of rheumatism with excessive pyrexia in a man 54 years old. On the eighth day of the illness the temperature by mouth registered 107.2 deg. F. with a pulse rate of 128 beats per minute. Just prior to using an ice pack the temperature in the rectum rose to 109.3 deg. A three-quarters of an hour application of the pack resulted in reducing the temperature to 107 deg. F. The author finds only two cases recorded in British literature where a recovery followed so high a temperature in rheumatism, and in both of these cold baths had been employed.

Stokes-Adams Disease.— Steiner (Boston Medical and Surgical Jour., Aug. 9, 1906) says that Stokes-Adams disease is an affection which presents clinically the following features: (1) A slow pulse, usually permanent, but sometimes paroxysmal, falling to 40, 20, or even to 6 beats per minute; (2) cerebral attacks which consists in vertigo of transient character, syncope, pseudoapoplectiform attacks or epileptiform seizures; and (3) visible auricular impulses in the veins of the neck, the beats varying greatly, as 2:1 or 3:1 rhythm being the most common (Osler). During the last three years the author has seen three cases, which he details. The first patient, a man, aged 77, had recurrent syncopal attacks in the same month at intervals of a year or more, a slow pulse, venous pulsation in the neck, arterio-sclerosis and cardiac hypertrophy. There was a gradual improvement during the further course of the disease. The second patient, a man 53 years old, had one epileyptiform seizure and one attack of syncope apparently at the onset of the malady. The pulse was slow, venous pulsations in the neck were absent, slight arterio-sclerosis and hypertrophy of the heart. A brief sojourn at "Bad Nanheim" afforded no relief. The patient died two years after the apparent onset. During the course of the disease the pulse ranged from 37 to 19. The third patient, a woman, 51 years old, suffered from syncopal attacks, slow pulse, venous pulsations in the veins of the neck and cardiac hypertrophy. The pulse rate averaged 40 per minute.

Spontaneous Rupture of the Heart in a Case of Senile Dementia —Miller's (Boston Medical and Surgical Jour., Aug. 2, 1906) patient was a man 83 years old, who had a spontaneous rupture of the heart as a result of myomalacia cordis, the accident being determined by mental and physical excitement. The rupture occurred at the site of an old infarct near the top of the left ventricle. The age of the patient, the condition of the arterial system, were favoring conditions almost invariably cited in cases of spontaneous heart rupture. The pre-existing myocardial disease, anemic necrosis, is regarded as a less frequent cause of heart rupture than other degenerative diseases of the myocardium.

Id.—Palmer describes a remarkable case of spontaneous rupture of the heart in a man, 36 years of age. The rupture occurred in the pleural cavity and was probably determined by the obliteration of the pericardial cavity through the formation of adhesions which existed over the greater surface of both auricles and ventricles. The patient presented the physical signs and symptoms of aortic aneurism, accompanied by symptoms of pressure on the left recurrent laryngeal nerve. The slight enlargement of the descending portion of the aortic arch present could not have possibly been responsible for this clinical picture. The coronary arteries were in an advanced stage of arteritis, while the systemic vessels were normal.

Intermittent Pentosuria and Glycosuria.—Kaplan (N. Y. Med. Jour., Aug. 4, 1906) divides pentosuria into: (1) Chronic pentosuria, occurring when the excretion of pentose in the urine is constant, and when glycosuria cannot be induced after the ingestion of one hundred grams of glucose. (2) Alimentary pentosuria occurring in individuals who cannot oxidize large amounts of pentosans introduced with the food, exerting a portion of the pentosan as pentose; when the articles containing these pentosans are excluded from the dietary the pentose disappears from the

urine. (3) Intermittent pentosuria, occurring when the excretion of pentose takes place at more or less regular intervals uninfluenced by external conditions and when one hundred grams of glucose will not give rise to a glycosuria. (4) Intermittent pentosuria and glycosuria. When this condition occurs pentose is present in appreciable quantities, and glucose appears in the urine, either independently or after the administration of one hundred grams of glucose.

The Influence of Excessive Meat Diet on Growth and Nutrition.—Watson's (Lancet, July 21, 1906) paper deals with the clinical results obtained by feeding rats on an exclusive meat diet. His experiments prove that the use of such an excessive meat diet is attended by a retarded growth, and sterility is induced if the diet is commenced in early life. The power of lactation is diminished—a permanent weakening of the resisting power of the animals is induced by the use of excessive flesh diet in early life, the animals succumbing to disease at an unusually early age, and there is a high death rate in the offspring of animals fed on excessive meat diet. Clinical experience leads Watson to think that there is also a close parallel in diseases of the human subject, and especially in that class of affections commonly included under the terms of gout and goutiness. He mentions that particular attention should be given to early dietetic history of patients as far as obtainable.

A Simple Test for Biliary Pigments in the Urine.—Krokiewicz (Bulletin général de therapeutique, May 23, 1906) recommends a test consisting of aqueous solutions of sulphanilic acid (1 per cent) and sodium nitrite (1 per cent) as highly sensitive for bile pigments in the urine, and that its application is not affected by the presence of other substances. The test is carried out as follows: Equal quantities of the sulphanilic acid and sodium nitrite solution ($\frac{1}{2}$ cc.) are placed in a test tube, to which an equivalent quantity of urine (1 cc.) is added. The mixture is shaken for ten or fifteen seconds, and if the urine contain bile pigment the solution will become a ruby red, which upon the addition of one or two drops of hydrochloric acid changes to a violet amethyst.

Microbic Cyanosis.—Gibson and Douglas (Lancet, July 1, 1906) relate an interesting case of a woman, 36 years of age, who had been subject to headaches, weakness, attacks of dizziness and faintness for some years The appearance of the skin was of a distinctly cyanotic tint. Gastric as well as enteric disturbances frequently evidenced themselves, and for some time there had been a tendency to diarrhea. The hematologic examination presented the following: Red blood corpuscles less than 4,000,000; the hemaglobin amounted to 70 per cent; the leucocytes were above 10,000. The blood, save that of a slight secondary anemia, was otherwise normal. The physical examination was negative. A bacteriologic examination of the blood gave a pure culture of bacillus coil communis. The condition, therefore, belongs to the group of affections often termed false cyanosis.

Tuberculin in the Treatment of Tuberculosis.—Pogue (Med. Record, Aug. 4, 1906) deducts the following conclusions from a study of 167 cases: An early diagnosis is the most important step to the successful treatment of tuberculosis. Tuberculosis may be arrested by proper treatment, with a certainty of a permanent cure. Tuberculin is a valuable adjuvant in the treatment of tuberculosis, as is evidence by the recovery of twenty-eight out of thirty cases that were treated with practically nothing but tuberculin while they continued to follow their ordinary occupation during the treatment. Cases of tuberculosis treated with the addition of tuberculin show a much less tendency to recur than similar cases treated without tuberculin. Tuberculin in small doses (0.01 to 0.005) seems to have a more curative action than when given in large and increasing doses. No ill effects follow the administration of small doses of tuberculin. Purely incipient cases improve very rapidly under the use of small doses of tuberculin, both as to the arrest of the disease and the clearing up of the diseased area. Tuberculin should never be given to a patient who has a fever or who is suffering from mixed infection. Third stage cases, especially advanced cases, receive little or no benefit from the use of tuberculin.

The Loss of Patellar-Reflex in Pneumonia.—Barnes (Birmingham Med. Review, April, 1906) like Hughlings Jackson, observed a loss of knee and other reflexes in cropuous pneumonia, while in pulmonary consoildations due to tuberculosis and septic pneumonias the reflexes invariably persisted until death. He noted an absence of the patellar reflexes in thirty out of thirty-four cases of croupous pneumonia. A disappearance of the knee reflex on the first or second day generally indicates a severe attack with a bad termination. In those cases which ended fatally, the author was able to demonstrate changes in the third lumbar segment. Barnes believes that the absence or presence of the knee reflexes is not only a valuable differential sign, but also a guide to the prognosis.

DEPARTMENT OF LEGAL MEDICINE.

R. B. H. GRADWOHL, M. D.

Death from Electricity.— Kratter (Veirteljahrsschrift fuer Ger. Medizin, Band XXX Heft 2, Proceedings of the German Association of Legal Medicine) has contributed several monographs upon the subject of death from electricity. He opened the discussion of this subject anew at this convention by dividing the subject into three headings, viz.: 1. What is death by electricity? 2. How can the diagnosis of death from electricity be verified? 3. Which current can kill a man?

Knowledge can be gained of the fact that death is caused by the electric current by the many deaths of persons and animals by accident and the pathologic-anatomic changes found in them; secondly, by experimental researches upon animals with this current. Death occurs suddenly in some, sometimes with an outcry, sometimes without it, with only tetanic-like convulsion of the body, without leaving any visible traces upon the outside of the body. In other cases death does not occur immediately, there is loss of consciousness, a soporific effect of the current, death finally taking place with sterterous breathing and gradually increasing cyanosis. In experimental animals where naturally observation can be more acute, there is remarked a difficulty in breathing at first, followed by conclusion of the entire muscular system. The breathing difficulty is either permanent (death), or begins after a quarter, a half or an entire minute, and gradually is restored. Jellinke has observed other phenomena; at the moment of contact, there is a spasm of the entire circulatory system, with an enormous increase in the blood pressure, this going far to explain the hemorrhaes which have been described in some cases of electric shock. This can be determined by the sphymographic tracings, which show that if the breathing stops for any long period of time, there is a sinking in the blood pressure, with almost impreceptible movement of the pulse and very slight palpable heart's action. This is the picture of an asphyxiation.

The anatomic picture found in these cases does not differ either in man or in animals. The blood in the body is very fluid, or with very slight clots in the bodies of animals, of a dark color, over-filling of the lungs and heart and great vessels with blood, many ecchymoses visible to the naked eyes in places in the body, just as we find them in drowned bodies. In one case Kratter found ecchymoses under the endocardium of the left heart, as Dietrich has pointed out in cases of death from sun-stroke. The venous system of the chest is enormously distended with blood, much more so than can be accounted for on the basis of a post mortem filling by gravity; this is not an artefact, but is found in every case of death by asphyxia as well as in electric deaths. As Kratter said before, "death by electricity is a central respiration paralysis, a special kind of internal asphyxia."

What changes take place in the central nervous system as to lead to death by asphyxia was the subject of an inquiry by Kratter; he made sections of the spinal cords of two subjects, one human and one experimental animal, dying from the electric stream. He made out minute hemorrhages. Corrado found in the brains of dogs killed with the current decided changes in the ganglion cells of the cortex. These changes were in the shape of distortion of the nuclei and chromatin substance and vacuole formation. There was a condition of varicose atrophy. Kratter is unable to confirm Carrado's findings. Neither can Jellinek confirm the same, although he has made many sections of animals dying from the current.

In short, Kratter inquires, "Can we accurately draw a picture of the pathologic anatomic findings in a case of electric death and make a diagnosis thereon? He replies, that we cannot and for the following reasons: 1. The peculiar character of the current and lack of control over the same makes it impossible to reason on one case from all cases. It is a fact that much more severe changes than are found in cases of electric death are produced in the brains of men who rally survive. 2. Experiments and clinical cases of electric shock show us that reparable effects are sometimes produced by the current from which the animals recover.

It is a fact that while the anatomic diagnosis cannot be distinguished from that of "shock" in the ordinary expression of the term, as regards the effect upon the internal organs, yet fortunately the effects of the current upon the exterior of the body serves to make a competent diagnosis, i. e., the effects of burns either from lightning or from actual electric shocks from motors, etc. The burns produced in industrial accidents are characteristic; a long blister usually upon the index finger of the hand receiving the shock. Other means of diagnosis depend upon the point where the shock was received in the body, burning and tearing of the clothing, foot or head apparel, in lightning deaths burning and melting of metallic substances like watches, watch chains, etc., on the body, and magnetization of iron substances on the body, such as knife blades, keys, etc.

As to the third question, what kind of a current can kill, there arises an important question, theoretic as well as practical. It can be accepted as a fact that a current with a voltage of 500 is dangerous, and the danger increases as we go over the 500 mark. This rule varies with individuals as a rule. For instance, men have been killed by a current of 250 volts and others have survived a current of over several thousand volts. It is a well-known fact that currents of 20 milliamperes are used for medicinal purposes. A current of 100 M. A. is a dangerous. Moisture of the skin increases the effect of the current, as well as salt solutions and acid solutions upon the skin.

The idiosyncrasy of certain persons to the current must not be forgotten. Alcoholics, patients with heart disease and lymphatic trouble, as well as youthful people in general are quite susceptible to the current. Alternating currents are more dangerous than the direct.

GENITO-URINARY.

T. A. HOPKINS, M. D.

An Analytical Study of Uremia.—Dr. A. C. Croftan, Chicago (Jour. A. M. A.), criticises the current theories of uremia, showing that neither anuria nor the variations of excrementitious nitrogen output suffice to explain the phenomena. Only when we determine separately the various groups of nitrogen bodies that occur in the blood and urine do we find abnormal conditions that may be deemed fairly characteristic. The two most important of these are: 1. A relative increase of the ammonia salts, both of the blood and urine as compared to normal average values and as compared to the circulating and excrementitious urea. 2. A relative decrease of the urea, both of blood and urine as compared to normal average values and to the total nitrogen of the circulating and excrementitious nitrogenous waste products. There may also be highly toxic albuminoid or alkaloid bodies in the blood or urine that might have an enormous effect without appreciably changing the amount or relative proportions of the nitrogen content. As regards the inorganic salts, the most delicate tests, Croftan states, give little evidence that uremia is due to salt retention. That there must be some poisons acting in the productions of uremia can not be denied. The decreased urea secretion, Croftan is inclined to think, is due rather to non-formation than to retention. It is not increased in the blood, as it should be if it were merely not eliminated, and the corresponding increase of ammonia is normally concerted into urea. Disturbances of the kidney and liver, Croftan states, often are seen to go hand in hand, and he believes this would be found much more frequently if the liver were examined as thoroughly as the kidneys in every case of Bright's disease that comes to autopsy, and if mild functional disorders of the liver were as easily recognizable as like disorders of the kidney. Even if the kidneys are primarily share the function of eliminating toxic matters and some of the most important of these must pass through the liver before being finally eliminated by the kidneys. Even if the kidneys are primarily diseased more work is thrown on the liver, not only in its disintoxicating function, but also in making up for the waste caused by a leaky kidney. The organ consequently becomes fatigued, its function of disintegration of albumins is impaired and less urea and more incompletely disassimilated intermediary products of albuminous metabolism are thrown into the circulation and intoxication results. Though this may thus follow or accompany renal disease, it is still due more to hepatic than to renal insufficiency. Hence the importance of recognizing early even mild degrees of hepatic insufficiency (particularly in renal cases and in pregnant women) and of safeguarding the patient against anything that may suddenly impose a strain on the fatigued liver. Instead, therefore, of stimulating the kidneys, the chief object of treatment should be to prevent development of uremia by attention to those organs that threaten to fail. Croftan advises first rest for the liver, even starvation for a few days, and in any case complete elimination from the diet of all substances irritating to the organ, and that every effort should be made to reduce intestinal putrefaction to a minimum. He would follow this by mild stimulation, the carefully guarded use of salicylates, of bile acids, possibly of calomel, and such dietetic and physical means as are available, all under careful supervision. For the acute uremic attack the most sensible procedure, he says, is blood letting, a lost art that should be revived in such cases as these. The injection of a saline to replace the lost fluid can do no harm, especially if some salt is injected that can stimulate the hepatic function, e.g., salicylate of soda in normal salt solution, or a solution of sodium citrate or phosphate in proper molecular concentration. Symptomatically, he has seen good results from the use of such infusions.

The Rational Treatment of Urethritis.—N. E. Aronstam M.D., Detroit, Mich. (Jour. A.M.A.), condemns the so-called abortive plan of the treatment of acute urethritis and

also the so-called expectant plan of treatment. Not less reprehensible, he states, are the remedies in vogue at present, prominently among these, figure the "alkaline diuretics." The author claimes that alkalies when absorbed are completely destroyed as far as the acid radicle is concerned, being converted into normal chlorids or salines and not carbonates, and he states that they exert beneficial effect on the inflamed urethra, not as alkalies, but as diluents and diuretics. The therapeutics value of boric acid and salol is also doubtful; balsamics are condemned, presumable benefit from these remedies being due to the water taken in them. In the acute stage the patient should take plenty of water, avoiding alcohol, tea and coffee, and condiments as well as soups and nitrogenous foods. The anterior urethra is flushed with a normal saline solution by means of the Valentine douche or similarly devised apparatus, with a good valve attachment to regulate the flow. The apparatus should not be elevate higher than six feet. The urethra having been cleansed, 20 minims of a solution adrenalin (1:1,000) is instilled through an ordinary bulb eye dropper into the canal, retained five minutes and allowed to escape. The saline irrigations are continued once or twice daily for ten days, after which potassium permanganate is substituted in ascending strength, 1:10,000 to 1:1,000 at the end of the third week. By this time the discharge will have ceased, or nearly so, and a prescription of zinc sulphate, adrenalin and colorless fluid extract of hydrastis in distilled water may be used, which, in a short time, will check it completely. Three weeks suffice in the majority of instances to effect a cure. The treatment of the chronic form of urethritis is more difficult, tedious and complicated than that of the acute variety. The author recommends as an injection a solution of protargol (5 per cent) together with adrenalin chlorid and Magendie's solution of morphine if necessary. In some cases silver nitrate acts more favorably than other silver compounds. Irrigations with potassium permanganate or zinc sulphate may be useful. The introduction of sounds is indicated: first, in incipient and formative stages of stricture; second, in involvement of the posterior urethra without implication of its adnexa; third, as a powerful stimulant to the urethra in catarrhal treatment affecting its anterior segment, where no gonococci are demonstrable. The author recommends urethroscopy for table practice as a means of diangosis and as a therapeutic auxiliary. The value of internal treatment in chronic gonococcic urethritis is questionable. The proper treatment in all cases depends on determination of the seat of the lesion. The three-glass test of the urine should be used, and sound introduced to detect strictures and diverticula. Rectal examination is imperative in nearly all cases, and search must be instituted for possible diseased conditions of Cowper's glands as this is apt to cause an obstinate urethrorrhea. Folliculitis of the urethral mucosa may produce a mucopurulent discharge. Meatotomy and circumcision should be performed in proper cases. Affections of the bladder, ureters and pelvis of the kidneys or of the kidney itself must attract attention as possible causes in all ultra-chronic cases. Cystoscopy and, if necessary, ureteral catheterization should be performed before definitely arriving at a diagnosis. In conclusion the author remonstrates against unscientific methods of treatment and the failure to recognize the gravity of gonococcic urethritis. The treatment undertaken by the physician must be in conformity with the most modern principles governing it.

Some Observations on Prostatectomy.—L. Bolton Bangs (Med. Record) considers the following factors in deciding whether or not to advise prostatectomy; the general condition of the patient, his social condition and environment, his temperament and his accessiblity to judicious medical advice and assistance; whether or not catheter life is likely to fail, and, if it has failed, in what degree; and, finally, what measure of relief is to be gained if, after the operation, some imperfection should remain which is insignificant in comparison with the prior condition. The writer then gives the histories of a number of patients which show how often significant symptoms are appreciated or overlookled. He speaks of certain cases in which small prostates have been removed when there were few or no signs of obstruction. In these cases it was not recognized that chronic interstitial cystitis had reduced the capacity of the bladder so that frequent urination had become a necessity. Each case must be studied by itself. The final outcome of the operation cannot be foretold definitely, but when the indications are clear it can be wisely advised on account of the great relief and comfort which result.

In protracted cases of summer complaint give freshly pressed grape and other juices to prevent scurvy.

For toothache nothing is better than oil of cloves and tincture opium, equal parts, applied to the aching tooth on a pledget of cotton, says Dr. J. L. Fennel.

THE MEDICAL FORTNIGHTLY

A Cosmopolitan Biweekly for the General Practitioner

The Medical Fortnightly is devoted to the progress of the Practice and Science of Medicine and Surgery. Its aim is to present topics of interest and importance to physicians, and to this end, in addition to a well-selected corps of Department Editors, it has secured correspondents in the leading medical centers of Europe and America. Contributions of a scientific nature, and original in character, solicited. News of Societies, and of interesting medical topics, cordially invited.

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MEDICAL MISCELLANY

LEPROSY HOSPITAL IN THE HAWAIIAN ISLANDS.—Dr. Walter R. Brinckerhoff, of the Harvard Medical School, has received the appointment as director of the United States Government Leprosy Research Hospital which is established on Molokai, the island on which the lepers are now segregated. Dr. Brinckerhoff lately sailed and is now in charge at Molokai.

SUIT FOR CERTIFYING TO GONORRHEA.—The annual report of the London and Counties Protection Association contains, as usual, an account of various actions taken or threatened against physicians, which as a rule the association was successful in defending. One case, which was unsuccessfully defended, is of particular interest. A physician wrote on a certificate the fact that a member of a sick club was suffering from gonorrhea and gave this certificate to the secretary of the club. The member brought an action for libel and slander. The physician pleaded that the communication was privileged, but the jury decided against him and awarded $750 damages to the plaintiff. The case shows that a physician should never give his opinion of the nature of an ailment to any one but the patient without the latter's consent in writing or in such form as to be capable of legal proof. The solicitors of the association state, in commenting on the case, that when a physician, in the course of his duties has to fill up a club certificate, and the ailment is on the disclosure of which would constitute a libel, he ought to give the certificate to the patient (not to a third party, as in this case). Then any responsibility for disclosure to others would not rest entirely with the patient.—J. A. M. A.

PHARMACOPEIAL OR PROPRIETARY PREPARATIONS: WHICH?— Dr. J. Ritter, Chicago (Jour. A. M. A., Sept. 1), discusses the task confronting the medical profession of providing an effective method of checking the practice now in vogue with many of its members of prescribing and recommending various proprietary preparations, many of which are fraudulent. It is difficult, he states, to draw hard and fast lines regarding what constitutes an ethical preparation in contradistinction to the so-called nostrums. He declares that it is not good practice to condemn in toto, as undoubtedly even some nostrums possess therapeutic properties, since in their composition well-known drugs are used. Ritter states that it would be a good plan for physicians and druggists alike to look into the composition and combination of all new chemical and synthetic and Galenical preparations, not excluding the "patented" nostrums which from time to time are offered to physicians as therapeutic agents. He refers to the claims made for the various cod-liver oil preparations on the market and states that by the addition of expectorants, anodynes and corrigents a pleasant-tasting elixir, cordial or tonic is made which does not contain a trace of cod-liver oil. He advises physicians to devote about half an hour daily to studying the Pharmacopeia, a good dispensatory, or the National Formulary, in order to acquaint themselves with good, reliable and accurate formulae and remedies.

CAUTION.—The season is approaching when sudden changes may endanger the health of your delicate patients, especially those suffering from bronchial and pulmonary troubles. In addition to giving good advice as to proper clothing and the importance of keeping the feet dry and warm, prescribe McArthur's syrup of hypophophites for the convalescent, and thus forestall any tendency towards tuberculosis, and promote a prompt return to health.

MR. GARDNER: "Well, dear, how are the tomatoes you planted?"

Mrs. Gardner: "Oh, John! I'm afraid we'll have to buy what we need this year."

Mr. Gardner: "Why, how's that, Mary?"

Mrs Gardner: "I recollected today that when I did the planting I forgot to open the cans!"